MDR Tracking Number: M5-04-3403-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on June 7, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The manual therapy technique, office visit, chiropractic manipulation, range of motion, physical performance test, functional capacity-functional capacity evaluation, therapeutic exercises, 97113-aquatic therapy/exercises, 97124-massage therapy and mechanical traction from 08-21-03 through 11-04-03 **were found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-16-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following identifies the disputed services and Medical Review Division's rationale:

In accordance with Rule 129.5, the requestor submitted relevant information to support delivery of service for CPT code 99080-73 (work status report) on date of service 08-29-03 and 10-03-03. The carrier denied the report billed on 08-29-03 for unnecessary medical treatment and the report billed on 10-03-03 was denied for unnecessary medical treatment based on a peer review however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical review division has jurisdiction in this matter and therefore, recommends reimbursement in the amount of $30.00 in accordance with the Medicare Fee Guidelines.

The work hardening program billed for dates of service 10-08-03 through 11-04-03 was preauthorized under #16585 and #16585-IC. Therefore, this review will be per Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(e) (5) (c), reimbursement shall be $64.00 per hour minus 20% if non-CARF accredited.

- 97545-WH- Recommend reimbursement of $102.40 (6 units) x 17 days = $1740.80
- 97546-WH- Recommend reimbursement of $307.20 (6 units) x 11 days = $3379.20
- 97546-WH- Recommend reimbursement of $256.00 (5 units) x 5 days = $1280.00
- 97546-WH- Recommend reimbursement of $153.60 (3 units) x 1 days = $153.60
- On 10-30-03 the requestor billed 2 units of 97545-WH. The carrier made payment of $57.60. Recommend additional reimbursement of $44.80.
- On 10-30-03 the requestor billed 3 units of 97546-WH. The carrier made payment of $86.40. Recommend additional reimbursement of $67.20.

The requestor billed 99213 for date of service 11-14-03 and 11-18-03. The carrier paid $118.00. According to the Medicare Fee Schedule the MAR is $62.81 per CPT code 99213 billed. Therefore, recommend additional reimbursement of $7.62.

This Findings and Decision is hereby issued this 8th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 08-21-03 through 11-18-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

NOTICE OF INDEPENDENT REVIEW DECISION

September 1, 2004

Rosalinda Lopez **AMENDED LETTER 09/27/04**
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3403-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care

professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 47 year-old male injured his anterior neck and chest on ___ while he was using a mechanical saw to cut concrete. The saw became stuck and he began pulling it free when it suddenly became loose and struck him. His initial diagnoses are displacement of cervical intervertebral disc without myelopathy, cervical radicular syndrome of the right upper extremity, myalgia and myositis (unspecified), sprain of the right shoulder and upper arm and neck laceration. He has been treated with therapy, a work hardening program and pain medications.

Requested Service(s)

97140 – manual therapy technique, 99213 – office visit, 98943 – chiropractic manipulation, 95851 – range of motion, 97750 – physical performance test, 97750 – functional capacity – functional capacity evaluation, 97110 – therapeutic exercises, 97113 – aquatic therapy/exercises, 97124 – massage therapy and 97012 – mechanical traction for dates of service 08/21/03 through 11/04/03; functional capacity evaluation for date of service 11/04/03.

Decision

It is determined that the manual therapy technique, office visit, chiropractic manipulation, range of motion, physical performance test, functional capacity – functional capacity evaluation, 97110 – therapeutic exercises, 97113 – aquatic therapy/exercises, 97124 – massage therapy and mechanical traction for dates of service 08/21/03 through 11/04/03 were medically necessary to treat this patient's condition. In addition, the functional capacity evaluation for date of service 11/04/03 was medically necessary. Reports or dates of service 10/08/03 through 10/30/03 were not reviewed.

Rationale/Basis for Decision

Medical record documentation indicates the necessity for the treatments in question. National treatment guidelines allow for this type of treatment for injuries of this nature. Based upon the diagnostic testing and the patient's response to the initial treatment, continuation of care was appropriate. Each date of service was properly documented and services were justified based upon the significance of this patient's injures as documented by diagnostic testing and exam findings. The patient improved with treatment and progressed to the point where a work hardening program was pre-authorized and completed. After this program it was medically necessary for another functional capacity evaluation to be performed to document his ability to return to work, therefore all treatments in question were medically necessary to treat this patient's medical condition.

Sincerely,